PRINTED: 08/19/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-				
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPI	LETED	
		155608	B. WIN			07/26/2	2011	
NAME OF I	NAME OF BROWNER OF CURRITIES			STREET	ADDRESS, CITY, STATE, ZIP CODE	_ Į		
NAME OF	PROVIDER OR SUPPLIER	K		1200 E	AST LUTHER DRIVE			
	BERG LUTHERAN		_		N POINT, IN46307			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE	
F0000								
•	This visit was fo	or the Investigation of	F0	000	Please let us know if this co	ould be	<b>i</b>	
	Complaint IN00	_			"Paper Compliance". Than			
	· · · · · · · · · · · · · · · · · · ·				you, Tami Adams, Administr	ator		
	Complaint IN00	093516 substantiated,			219-661-3301Tamara Zimmerman, DON 219-661	l l		
	Federal/State de	ficiencies related to the						
	allegations are c	ited at F 282 and F 309.						
	Survey dates: Ju	aly 25 and 26, 2011						
	   Facility number:	000515						
	Provider number							
	AIM number: 1							
	Anvinumoer. 1	00230820						
	Survey team:							
	Janelyn Kulik, R	RN						
	Census bed type							
	SNF/NF: 149	•						
	Total: 149							
	10tai. 149							
	Census payor ty	pe:						
	Medicare: 21	•						
	Medicaid: 80							
	Other: 48 Total: 149							
	101.11.149							
	Sample: 8							
	These deficienci	es also reflect State						
	findings cited in	accordance with 410 IAC						
	16.2						1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D4IO11

Facility ID: 000515

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPL	OMPLETED	
		155608	B. WING 07/26/201			011		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				AST LUTHER DRIVE			
WITTENE	BERG LUTHERAN	VILLAGE			N POINT, IN46307			
				L	11 On 11, 111-10007			
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE	
	· ·	ompleted 7/28/11						
	Cathy Emswiller							
F0282	•	ded or arranged by the						
SS=D		ovided by qualified persons						
	plan of care.	n each resident's written						
	-	review and interview the	EU	282	F282 Services by Qualified		08/10/2011	
			10	202	Persons/Per Care Plan 1.		06/10/2011	
		ensure physicians' orders			What corrective action(s) w	ill		
	were follow for I				be accomplished for those			
	· ·	cations used to treat			residents found to have been	en		
	bacterial infectio	ns) for 1 or 2 residents			affected by the deficient			
	reviewed with or	ders for IV antibiotics in			practice? Unable to correct t			
	a sample of 8. (F	Resident #H)		alleged deficient practice but  Resident was sent to ER for his  dose of antibiotics and Physician				
	Findings include	•			dose of antibiotics and Physi was aware. 2. <b>How other</b>			
	1	•			residents having the potent			
	The record for D	esident #H was reviewed			to be affected by the same	iai		
					deficient practice will be			
		5 a.m. The resident was			identified and what correcti			
	admitted to the fa	acility on 7/8/11.			action(s) will be taken. A ch	nart		
					audit was completed for any			
	The resident's dia	agnoses included, but was			admissions or re-admissions			
	not limited to, ch	ronic obstructive			6-26-11 through 7-26-11 with			
	pulmonary diseas	se, coronary artery			antibiotics ordered that could affected by the same alleged			
	disease, hyperten	sion, endocarditis			deficient practice. A chart au			
	, , ,	I the hear), sepsis (blood			was completed for any	٠.٠		
	infection), and lo	/· • ·			admissions or re-admissions	from		
	(swelling).	wer leg edema			6-26-11 through 7-26-11 for			
	(Sweimig).				timeliness of physician notific			
	A.D. (* A.M. 1"				and timeliness of orders rece	eived		
		ation Instruction Sheet			for new admissions or	tod		
	•	dated 7/8/11 at 9:21			re-admissions. Audit complet on 7-26-11 with no deficienci			
		ne resident was to receive			3. What measures will be			
	Ampicillin (antib	piotic) 2 g (grams) IV			into place or what systemic	-		
	every four hours.	The resident's next dose			changes will be made to			
	was due 7/8/11 a				ensure that the deficient			
					practice does not recur.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155608 07/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 EAST LUTHER DRIVE WITTENBERG LUTHERAN VILLAGE **CROWN POINT, IN46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Admission Medication/Treatment Orders policy revised on August Review of a physician order statement 2, 2011 Admit audit revised on dated 7/8/11, indicated the resident was to August 2, 2011 Preadmission receive Ampicillin 2 g every four hours at Clinical Assessment - Nurse 3:00 a.m., 7:00 a.m., 11:00 a.m., 3:00 Liaison will document the name(s) of antibiotic(s) the p.m., 7:00 p.m., and 11:00 p.m. physician ordered at the hospital along with the administration Review of the July 8, 2011 medication times. Preadmission Clinical administration record indicated the first Assessment - Nurse Liaison will document the time the last dose does of Ampicillin was signed out as of antibiotics were given at the being given on 7/9/11 at 7:00 a.m. hospital prior to admission at the facility. All nurses will be A nursing note dated 7/8/11 at 8:30 p.m., in-serviced on the revised Administration indicated the pharmacy called stating the Medication/Treatment Orders resident's medications were coming policy and the Preadmission tonight. The resident was informed his Clinical Assessment on August 9, medications were coming. He asked why 2011 and August 10, 2011. h 4. How the corrective action(s) they were not here when he came into the will be monitored to ensure the facility. The nurse stated, "I would paged deficient practice will not recur, (sic) MD (medical doctor) to inform". i.e., what quality assurance program will be put into place; On 7/26/11 at 1:30 p.m. the Director of and by what date the systemic changes will be completed. Nursing was interviewed. She indicated Audit to be completed with the resident had received a dose of each admission and Ampicillin prior to the 7:00 a.m. readmission With in 24 hours documented dose given. She further of admission. This audit is indicated she knew the resident had required on every admission with no end date. Quality received a dose of Ampicillin at 3:00 a.m. Assurance Committee to monitor it just had not been signed out as given. for Trends and Compliance. On 7/26/11 at 1:45 p.m. the Director of Nursing and LPN #1 were interviewed. LPN #1 indicated she had taken the call from the hospital prior to the resident

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED  A. BUILDING 00 COMPLETED			ETED		
155608		155608	B. WING			07/26/20	011
NAME OF F	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE ST LUTHER DRIVE		
WITTENBERG LUTHERAN VILLAGE					POINT, IN46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF	CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION DATE
IAG		cility. The hospital had	IA				DAIL
	indicated the resi	J 1					
		ad not told the nurse the					
		tics were due to be given					
		She further indicated she					
		ian at 3:30 p.m. on 7/8/11					
		lers with the physician at					
		dicated the physician					
	-	ently the resident was to					
receive the antibiotics and until she had							
	his order she could not order the resident's						
	medications from	n the pharmacy. She then					
	indicated the phy	vsician should have					
	known the reside	ent would have missed					
	doses of his antib	piotic.					
	This Federal tag	relates to complaint					
	IN00093516.						
	3.1-35(g)(2)						
F0309 SS=D	must provide the r to attain or mainta physical, mental, a	st receive and the facility necessary care and services in the highest practicable and psychosocial well-being, in the comprehensive					
		review and interview the	F0309		F309 Provide Care/Service for	or	08/10/2011
	facility failed to	provide (intravenous)			Highest well Being 1. What		
	antibiotics (medi	cations used to treat			corrective action(s) will be accomplished for those		
		ns) for 1 or 2 residents			residents found to have bee	n	
		ders for IV antibiotics for			affected by the deficient		
		ns in a sample of 8			practice? Unable to correct t		
	_	esident returning to the			alleged deficient practice but Resident was sent to ER for I		
	hospital to receiv	re antibiotics. (Resident				-	

D4IO11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED					
AND PLAN	OF CORRECTION			LDING	00		
155608		155608	B. WIN	IG		07/26/2	011
NAME OF	DD OT ADED OD CLIDDI IEI		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1200 EA	AST LUTHER DRIVE		
WITTENBERG LUTHERAN VILLAGE				CROWN	N POINT, IN46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#H)				dose of antibiotics and Phys	ician	
					was aware. 2. How other		
	Findings include	•			residents having the potent	tial	
	i manigs merade	·-			to be affected by the same		
		· 1 . //TT · · · · 1			deficient practice will be	_	
		esident #H was reviewed			identified and what correct		
		25 a.m. The resident was			action(s) will be taken. A cl		
	admitted to the f	acility on 7/8/11.			audit was completed for any admissions or re-admissions		
					6-26-11 through 7-26-11 with		
	The resident's di	agnoses included, but was			antibiotics ordered that could		
	not limited to, ch	nronic obstructive			affected by the same alleged		
	1	se, coronary artery			deficient practice. A chart au	dit	
		nsion, endocarditis			was completed for any		
	1				admissions or re-admissions	from	
	,	d the hear), sepsis (blood			6-26-11 through 7-26-11 for		
	infection), and lo	ower leg edema			timeliness of physician notific		
	(swelling).				and timeliness of orders receifor new admissions or	eivea	
					re-admissions. Audit comple	ted	
	A Patient Medica	ation Instruction Sheet			on 7-26-11 with no deficience		
	form the hospita	l dated 7/8/11 at 9:21			3. What measures will be	put	
	_	ne resident was to receive			into place or what systemic	;	
	· ·	piotic) 2 g (grams) IV			changes will be made to		
	· `	. The resident's next dose			ensure that the deficient		
	was due 7/8/11 a				practice does not recur.		
	was due //8/11 a	u 11:00 a.m.			Admission Medication/Treat		
					Orders policy revised on Aug		
	Review of a phy	sician order statement			2, 2011 Admit audit revised of August 2, 2011 Preadmission		
	dated 7/8/11, ind	licated the resident was to			Clinical Assessment – Nurse		
	receive Ampicillin 2 g every four hours at				Liaison will document the	•	
	3:00 a.m., 7:00 a	ı.m., 11:00 a.m., 3:00			name(s) of antibiotic(s) the		
	p.m., 7:00 p.m.,				physician ordered at the hos		
		r			along with the administration		
	Review of the In	aly 8, 2011 medication			times. Preadmission Clinica		
		• /			Assessment – Nurse Liaison		
		ecord indicated the first			document the time the last d of antibiotics were given at the		
	1	in was signed out as			hospital prior to admission a		
	being given on 7	7/9/11 at 7:00 a.m.			facility. All nurses will be		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155608		<u> </u>	LDING	nstruction 00	(X3) DATE SURVEY COMPLETED 07/26/2011		
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE			F	STREET A 1200 EA	AST LUTHER DRIVE N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	indicated the res facility. He was three, his speech dry. His mucous moist. His lung upper lobes with auscultated (hear lobes. He denied His oxygen was canula. A doubl (peripherally ins catheter-used of long periods of t an intact dry dre abdomen was ro sounds in four que plus edema to hi extremities. His tender to touch. blood pressure we 97.8, pulse 81, a 3:30 p.m. the phase of 1.30 p.m. the resident was alert and ori was clear, skin we mucous membra The resident indicated help outside of I.	erted central  IV access to be used over time) to his left arm with assing was noted. His und with active bowel uadrants. He had one s bilateral lower left foot was red and His vital signs were vas 120/46, temperature and respirations 20. At sysician was paged. At sident's orders were the physician. At 8:00 the was in the recliner. He ented times three, speech evarm and dry and his ane was pink and moist. icated he will need little			in-serviced on the revised Administration Medication/Treatment Orders policy and the Preadmission Clinical Assessment on Augu 2011 and August 10, 2011. h How the corrective action(s will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into pla and by what date the syster changes will be completed. Audit to be completed with each admission and readmission With in 24 hou of admission. This audit wibe required for every admission with no end date. Quality Assurance Committee to monitor for Treand Compliance.	sst 9, 4. c) the ecur, ce; mic	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D		(X3) DATE S	) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155608	B. WIN			07/26/2	011
		<b>I</b>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			AST LUTHER DRIVE		
	BERG LUTHERAN			<u> </u>	N POINT, IN46307		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY		DATE
		ations were coming					
	_	ident was informed his					
		e coming. He asked why					
	they were not he	re when he came into the					
	facility. The nur	se stated, "I would paged					
	(sic) MD (medic	al doctor) to inform". At					
	8:50 p.m. the ph	ysician was paged with					
	no reply. At 9:1	0 p.m. the resident's wife					
	called and inquir	ed as to why her husband					
	had missed dose	s of his medication. The					
	wife was inform	ed of the problem and the					
		vanted the resident sent to					
		nis medication. At 9:20					
	_	an was paged with no					
	1	e practitioner was paged.					
	1 ^ *	lered the resident to be					
		dose of IV antibiotics. At					
		spital was informed the					
	_	ng sent to the hospital for					
		-					
	_	picillin and was then					
	1 -	the facility. At 10:00 p.m.					
		per ambulance. At 11:30					
	_	returned to the facility					
		he hospital. The resident					
	indicated he rece	erved one dose.					
	Interview with R	Resident #H on 7/26/11 at					
	11:55 a.m., indicated the facility did not have his medication when he got to the						
		not been given his					
	1	as sent back out to the					
		ve his antibiotics.					
	nospital to receiv	ve ms antibiotics.					
	On 7/26/11 at 1::	30 p.m. the Director of					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155608			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155608	B. WIN			07/26/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
WITTENBERG LUTHERAN VILLAGE				1	AST LUTHER DRIVE N POINT, IN46307		
				L	V1 Oliv1, 11440507		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		erviewed. She indicated		-			
	_	received a dose of					
	Ampicillin prior						
		e given. She further					
	1	ew the resident had					
		of Ampicillin at 3:00 a.m.					
	1	en signed out as given.					
	On 7/26/11 at 1:	45 p.m. the Director of					
		N #1 were interviewed.					
		d she had taken the call					
		l prior to the resident					
	1	cility. The hospital had					
	1	ident was on two					
		ad not told the her the					
		tics were due to be given					
		She further indicated she					
		eian at 3:30 p.m. on 7/8/11					
	1	ders with the physician at					
		ndicated the physician					
	1 -	ently the resident was to					
	1	iotics and until she had					
		ald not send for the					
		ations from the pharmacy.					
		ed the physician should					
	1	resident would have					
		his antibiotic. She then					
	indicated she wa	s not sure what happened					
	1	or the medications was					
	faxed to the phar	rmacy. The Director of					
		d the nurse sent the order					
	1 -	as soon as she could have					
		d the resident. There was					
	no further inform	nation given as to why the					

Facility ID:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/26/2011
NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE			STREET A	ADDRESS, CITY, STATE, ZIP CODE AST LUTHER DRIVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	of the Ampicillinand the physician until 3:30 p.m.	e resident was 1:00 a.m., the next does a was due at 11:00 a.m. a had not been contacted relates to complaint			